



State of Washington
Legislative Budget Committee

Study of Nursing Home Regulations in Washington State

Report 95-9

Prepared by Abt Associates Inc.,
and the LBC

February 15, 1995

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Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other types of policy studies. Study reports typically focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included.

Reporting directly to the legislature, the LBC generally meets on a monthly basis during the interim between legislative sessions.

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STUDY OF NURSING HOME REGULATIONS IN WASHINGTON STATE

Foreword

This study of Nursing Home Regulations was mandated by the Health Care Services Act of 1993. The major portion of the study was conducted by the firm of Abt Associates Inc., under contract to the Legislative Budget Committee.

LBC staff retained responsibility for two portions of the study: 1) the use of Physician/Nurse Treatment Protocols in Nursing Homes, and 2) Governmental Costs Related to Nursing Home Regulation. Combined, these two portions of the study are referred to as the Nursing Home Regulations Study—Addendum.

This document contains the Executive Summary prepared by Abt Associates Inc., and the Addendum prepared by LBC staff. Also included are two appendices: Appendix 1 is a Summary of Recommendations prepared by LBC staff, and Appendix 2 provides agency responses to both the Nursing Home Regulations Study and Addendum.

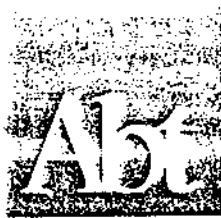
Individuals interested in obtaining a copy of the full Abt Associates report should contact the LBC at (360) 786-5171.

We appreciate the efforts of the Abt Associates study team, and gratefully acknowledge the cooperation of all parties who aided the study process. LBC staff support was provided by Bob Thomas, project supervisor, Larry Brubaker, Principal Management Auditor, and Robert Krell, Principal Management Auditor.

Cheryle A. Broom
Legislative Auditor

On February 15, 1995, this report was accepted for distribution by the Legislative Budget Committee.

Representative Jean Silver
Chair



Associates Inc.

**Study of Nursing Home
Regulations
in
Washington State**

December 22, 1994

Final Report

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EXECUTIVE SUMMARY

This report presents the findings and recommendations of a study of the costs and effects of nursing home regulation in the State of Washington, carried out by Abt Associates, Inc., under a contract with the State of Washington Legislative Budget Committee (LBC). The study was designed to assist the LBC in its overall review of nursing home regulations, which was mandated by The State of Washington Health Care Services Act of 1993 to examine federal, state, and local regulations and regulatory processes that apply to nursing homes in order to identify regulations that may be duplicative among the different regulatory programs, excessive, unnecessarily costly to comply with, or otherwise problematic.¹

Background on Nursing Home Regulations

In addition to the various local, state, and federal health and safety regulations common to many businesses and institutions, nursing homes in the United States are subject to a substantial set of regulatory requirements and processes established specifically for nursing homes by both the federal and state governments. This dual federal-state system reflects the states' historic responsibilities for licensing homes and the federal government's more recent responsibility for oversight in connection with its payments to homes.

Like all other states, the State of Washington requires that nursing homes be licensed by the State in order to operate. State regulations establish the criteria that providers must meet to obtain a license. In addition, since the passage of the Medicare and Medicaid Acts in 1965, the federal government has taken responsibility for a large share of nursing home costs. The Medicare Act provided federal funding for beneficiaries needing post-hospital convalescence; the Medicaid Act provided shared federal and state funding for longer term care of people who could not afford such care using their own resources. As part of its oversight responsibility for these payments, the federal government has established regulatory conditions for homes wishing to qualify for reimbursements under the Medicare or Medicaid programs.

State of Washington regulations apply to each of the 280 homes licensed to operate in Washington. Federal nursing home regulations apply to the 273 of these homes that are qualified for payment under Medicare and Medicaid. The two sets of regulations are by no means identical, but they cover the same general areas and have many common provisions. State regulations are often more detailed, filling in more specific requirements.

To avoid unnecessary duplication, nursing home compliance with both federal and state standards is determined by the state through annual, on-site inspections of facilities, commonly referred to as surveys, which are conducted by the Department of Social and Health Services (DSHS) staff. The costs of these surveys are partially reimbursed by the Federal Health Care Financing Agency (HCFA), which is responsible for design and development of the protocols,

¹ The Act also mandated a study of regulations that govern hospitals, which is being conducted by another independent contractor, Lewin/VHI.

tasks, and activities employed by DSHS staff during the survey to certify compliance with federal requirements.

Surveyors use a wide range of information sources to assess regulatory compliance: medical record reviews; resident, family, and staff interviews; and observations, kitchen inspections, and life safety code inspections. At the completion of the survey, the surveyors summarize their findings on a standard form, reporting any deficiencies that the surveyor has found in the provider's compliance with federal regulations together with evidence supporting that determination. Providers are required to develop a plan of correction. The plan must be approved by DSHS, which usually will also conduct a post-certification visit to determine that the corrections have been made.

The most recent major revision to the regulations, in 1990, reflected an accumulation of complaints with both the regulatory system and nursing home care. During the 1970's, both consumers and providers increasingly criticized the regulatory system as focused on structural and paper compliance rather than resident care and status. At the same time, various studies supported these criticisms of the system's inadequacy by documenting cases of inadequate care and abuse.² In 1983, the Institute of Medicine (IOM) assembled a committee of experts in the field to study nursing home quality and regulation and recommend changes to the system. The IOM Committee report noted that there was broad consensus that "government regulation of nursing homes...[was] not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation."³ A large number of studies of nursing home care during the 1970s had already identified cases of grossly inadequate care and abuse of residents in nursing homes. The IOM Committee heard testimony that as late as 1984 state studies of nursing homes and committee-conducted case studies showed that the problems identified in the earlier studies continued to exist in some facilities. Although incidents of abuse and neglect were considered to be less frequent than before, it was disturbing to the Committee that these practices were tolerated at all.

Primarily as a result of the IOM study, Congress, in its Omnibus Budget Reconciliation Act of 1987 (OBRA-87), mandated major changes in the nursing home regulatory process. The Health Care Financing Administration (HCFA) issued a set of draft regulations, with which facilities were required to comply beginning in October, 1990. These regulations adopted a new, more outcome-oriented approach, and substantially expanded provisions governing the quality of life and resident rights. The orientation towards outcomes means that regulations focus more on the results of care, as opposed to specific elements of care. Providers are required to render care and services that will attain and maintain the highest practicable physical, mental, and psychosocial well-being for each individual resident.

In terms of resident rights, facilities are required to notify the resident, the resident's physician, and a family member (or legal guardian) when the resident has had a significant

² Institute of Medicine, Improving the Quality of Care in Nursing Homes, National Academy Press, Washington, DC, 1986, p. 3. Also, see pp. 213-214 for references to 21 prior studies reviewed by the IOM Committee.

³ Institute of Medicine, op. cit., p. 2.

change in physical, mental or psychosocial status; when there is a need to alter treatment significantly; or when there is a decision to transfer or discharge the resident. To reinforce the idea that the nursing home is a home as well as a treatment facility, quality of life regulations assert each resident's right to self-determination of participation in activities, schedules, and health care consistent with his or her interests; to receive services in a manner that reasonably accommodates his or her needs and preferences; to live in a safe, clean, homelike environment; and to be treated in a manner that maintains or enhances each resident's dignity and respect.

Overview of the Study

The goal of this study is to identify, and where possible propose alternatives to, unnecessary or unnecessarily burdensome regulations or regulatory processes that increase the cost of care without yielding a commensurate improvement in the quality of care or the quality of life received by residents of nursing homes.

We selected 15 regulations for detailed review. These 15 regulations include the three regulations that were identified by provider organizations as being most troublesome to providers; ten of the fifteen state or federal regulations or areas most often rated by providers as "very problematic" or "very costly" in an LBC survey; and five regulations from among those that are most often cited in deficiency reports. Thus while the number of regulations studied is not large, it seems safe to say that they include the most likely candidates for reform based on either provider opinions or survey results.

Our findings for these regulations reflect the results of a further mail survey of all providers, follow-up telephone interviews with 37 of the respondents to the mail survey, visits to 20 facilities, meetings with DSHS surveyors and administrators, and meetings with representatives of both of the two provider organizations and four resident advocacy groups.⁴ Although they reflect these conversations, the findings and recommendations presented in this report are ours and should not be taken as reflecting the positions of the LBC or any other group.

Findings

This study focused on a small group of regulations, including those that providers rated as most problematic or most costly, as well as three identified by provider organizations, and five of the most often cited in annual surveys. As a result of our analysis, we are led to draw several conclusions:

⁴ The two provider associations we met with were the Washington Health Care Association and the Washington Association for Homes for the Aged. We also met with representatives of four resident advocacy groups: the Long Term Care Ombudsman, Washington Citizens for Action, Citizens for Improvement in Nursing Homes, and Evergreen Legal Services.

1) Providers usually feel that even very problematic or very costly regulations are necessary; they usually want changes in how those regulations are interpreted and/or operationalized.

Although we selected regulations that providers most often rated as very problematic or very costly, only one of the fifteen regulations was rated as unnecessary by a majority of providers in our follow-up mail survey. The issues raised by providers usually relate to changes in specific requirements or regulatory processes and not to whether the regulation is needed. In the one case where a majority of providers did rate the regulation as unnecessary (the regulation governing refusals of certain transfers), we agree with their perception and have recommended that the regulation be eliminated. (See our recommendations, below.)

2) Providers frequently complain of variation and inconsistency in surveyor interpretation. It appears, however, that providers' real issues are with excessive interpretation and the substantive requirements in the regulations.

Problems with surveyor inconsistency fell into two categories -- variation/inconsistency and excessive interpretation. The dominant theme was variation in interpretation among surveyors and, to a slightly lesser extent, inconsistency over time. However, as we discussed these problems with providers and examined our findings, we became less and less convinced that variation and inconsistency were in fact the most pressing issues in nursing home regulation. Every provider has examples of apparently outrageous interpretations, but their perceptions of variation and inconsistency are far more pervasive than their examples. Indeed, citations of surveyor variation and inconsistency seem to have little to do with providers' overall ratings of the regulations as either problematic or costly or with the specific issues that they raise in discussion.

It appears that variation and inconsistency may often be confused with problems involving excessive interpretation, or with substantive issues with the requirements of the regulation. Providers' examples of inconsistent interpretation almost always involve cases of excessive interpretation, since these are the ones that seize their attention. However, while a majority of providers rated thirteen of the fifteen regulations as suffering from inconsistent interpretation, they were far more selective in their perception of excessive interpretation. Only three regulations were rated by a majority of providers as having problems of excessive interpretation. Furthermore, unlike ratings of inconsistency, ratings of excessive interpretation seemed to reflect specific concerns related to that regulation. In two of these three cases, we found some substantiation for provider concerns. In the third case, it appears that providers' examples of excessive interpretation were in fact consistent with the guidelines and represent provider concerns with the regulation rather than issues of interpretation.

This does not mean that variation and inconsistency are not important issues. Rather, we think, it recognizes the intractability of the problem and the fact that inconsistent interpretation does not necessarily mean excessive interpretation. A recent evaluation of the survey process that Abt Associates conducted for HCFA found that while there is variation in the patterns of deficiency citations across the country, the underlying sources

of surveyor discretion that affect the process are similar. The survey process as it is currently designed requires surveyors to assess complex situations based on their professional judgement and the information available from the medical records they review and situations that they happen to observe. Thus, while DSHS, for example, has a system for monitoring and reviewing surveyor deficiency citations, the process is still necessarily reliant on surveyor judgement and is likely to continue to be so.

3) While we agree with providers that paperwork and documentation probably involve substantial costs, it is not clear that there is potential for substantial savings or even how much of the burden is due to regulation alone.

The problem posed by documentation is well known and applies to the health care system in general as well as to the regulatory processes. This is reflected in a fairly universal health care tenet -- if it isn't documented, it wasn't done. But time spent in documentation is time not spent in direct care. Documentation is an expensive component of health care, but to date there is no satisfactory solution to the problem. Nor were the providers with whom we talked able to offer concrete suggestions.

The only indication that there might be some area for improvement came from contrasting provider and surveyor descriptions. Providers told us that they spend a great deal of time doing "defensive" charting in an effort to "second guess" what surveyors will consider adequate to describe a situation and justify a course of treatment, and that they often have to write the same thing in several places. Surveyors said that providers often fail to document the key issues, and that the documentation can refer back to other sections of the medical records, so that providers do not have to rewrite and resummairize things in multiple places.

The truth probably lies somewhere in the middle, suggesting that providers might try to work more closely with DSHS or individual surveyors to define what documentation is really required. However, based on the information that we received from providers, we have no way to judge the extent to which this would really reduce documentation burdens.

4) Providers are unable to provide useful estimates of regulatory costs. Estimates of costs vary enormously among providers, and are clearly unreasonably high in some cases, while omitting the costs of greatest concern in others. Likewise estimates of potential savings tended to focus on documentation, regardless of provider concerns.

The results of our cost analysis were neither convincing nor relevant. The variation in the estimates was often very large, with standard deviations from 0.97 to 2.6 times the mean. When we queried survey respondents we learned that there was in fact a great deal of variation in the tasks included in their estimates. Respondents also had a tendency to report costs for a series of related tasks without isolating the tasks required for an individual regulation; however, there was no consistent pattern that could be discerned. Further, providers' estimates of costs often do little to explain why they believe a regulation is either problematic or costly.

Nor were we able to use provider estimates of potential savings. These estimates also varied considerably. Moreover, they did not seem to relate to the issues raised by providers and thus did not reflect on the savings that might be achieved by addressing those issues. In some cases, for example, we knew that the cost estimates did not include the non-labor costs that appeared to be of greatest concern to providers, so that the estimates of potential savings could not reflect on these either. More generally, we found that provider descriptions of the source of savings tended to involve somewhat vague assertions of savings from reductions in paperwork, regardless of the issues with the regulation.

Recommendations

We recommend five actions, involving six of the 15 regulations as follows:

1) The LBC and DSHS should petition HCFA to eliminate the regulation governing residents' right to refuse certain transfers, that is, transfers to and from a distinct-part Medicare unit.

This regulation allows residents to refuse to be transferred from distinct-part skilled nursing units to ordinary care units when their condition improves to the point that they no longer need the special services of the skilled nursing unit. The regulation only applies to these transfers; all other within-facility transfers are covered under another regulation that simply requires advance notification and efforts to accommodate preferences. There seems to be no reason for singling out transfers from skilled nursing units.

In addition, the provision of the regulation that requires residents who refuse transfer to pay the skilled nursing unit rate is ineffective for residents whose costs are reimbursed under Medicare or Medicaid. This both defeats the intended incentives for such residents to weigh the costs of refusal and subjects privately paying patients to penalties not incurred by those whose stays are paid for under Medicare or Medicaid.

Finally, the regulation imposes unnecessary financial penalties on nursing homes that organize their services in order to provide skilled nursing care through specialized units. There is no apparent reason for penalizing what appears to be a reasonable organization of care by provider institutions.

2) DSHS should clarify the situations in which providers should undertake investigations of possible patient abuse.

This regulation requires providers to have a system for ensuring that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source are reported to the administrator and to state officials in accordance with state law. Providers must also conduct a thorough investigation of the incident. The issue is with the definition of "injuries of unknown sources;" it has been interpreted to mean any unwitnessed event that resulted in a bruise or skin tear. Thus, providers are required to conduct thorough investigations (and report to the state) on minor incidents and accidents that are not perceived to be potential abuse situations.

We believe that clarification of the intent of this regulation will substantially reduce the number of investigations without eroding resident protection against abuse. It appears that DSHS and providers have misread this regulation and are conducting investigations whenever residents are injured in any way. This seems to be far beyond the intent of the regulation, and providers rightly perceive that many of these are a waste of time and resources. We recommend that DSHS seek clarification from HCFA as to the intent of this regulation.

3) DSHS should pursue efforts to identify a subset of sections and/or items on the uniform comprehensive needs assessment protocol that are not relevant for short-stay rehabilitative residents. If this effort is successful, DSHS will need to apply to HCFA for a waiver of the MDS requirements for such residents.

In 1990, HCFA imposed a uniform, standardized comprehensive assessment instrument, called the Minimum Data Set (MDS) on all nursing home providers. The assessment is a fairly detailed, interdisciplinary assessment tool, divided into 17 sections, and is part of a required process of needs assessment and care planning.

Providers argue that the full MDS assessment process is unnecessary for short-term residents. The idea seems reasonable enough. However, we were unable to obtain definite suggestions as to exactly which sections of the assessment should be omitted for short term residents. We understand that DSHS recognizes that there are a number of issues surrounding the short stay patient, of which adequacy of the MDS assessment is one.

We understand that DSHS has met with providers to begin discussion of a number of issues relating to short-stay residents, including assessments. We recommend that DSHS

should address the immediate issue of assessments without waiting for these general discussions to be completed. Specifically, we suggest that DSHS proceed now to try to identify elements of the current assessment protocol that do not need to be mandatory for all short-stay residents and, if this effort is successful, apply to HCFA for a waiver of the MDS requirements for these residents.⁵

4) DSHS and provider organizations should work together to develop and communicate prototype systems to incorporate the Minimum Data Set (MDS) needs assessment and Resident Assessment Protocols (RAPs) into provider operating systems so that providers can then develop effective resident care plans.

The regulations concerning assessments and care planning are unusual in that they require providers to complete a specific assessment process using a standardized instrument (the MDS), and follow a series of protocols (the RAPs), rather than simply specifying an end goal such as adequate assessments. The intention was to assist providers in conducting a needs assessment that would feed directly into the development of a care plan, and to provide the basis for surveyor review of those assessments and care plans. However, if providers are unable or unwilling to incorporate such required processes into their actual operating systems, then the regulation becomes a paper requirement, imposing costs to no end.

Assessment and care planning processes were part of nursing home care long before the OBRA-87 regulations. As a result of OBRA-87, HCFA developed a uniform assessment form, protocols, and care planning requirements and required all nursing homes to use the assessment, referred to as the MDS. Much of the excessive cost that providers perceive to be associated with the MDS appears to derive from the fact that they have simply added it on top of their own assessment process. In many facilities, the MDS has become a paper requirement, with little content or effect. In contrast, several providers who have incorporated the MDS into their own systems reported that it is in fact useful.

It appears that all parties might act to address this situation. Providers need to move to incorporate the required process within their own system. At the same time, the application of these forms to actual patient care does require some effort, and providers should be assisted in developing the necessary systems.

HCFA, DSHS, and provider organizations should work to develop prototype systems and otherwise encourage and assist providers in incorporating such mandated processes into their operating systems. By the same token, HCFA should be cautious in revising the

⁵ We should note, however, that the MDS may serve as the basis for classification of residents in any casemix reimbursement system that the State or the Medicare program may implement in the future. All assessments will, of course, have to include the items needed for classification.

MDS too often, recognizing that such revisions may entail a series of changes if they are to be incorporated into providers' internal operating systems.

5) DSHS should revise its procedures to explicitly require that surveyors support citations of nursing homes for hazardous situations with both an assessment of the seriousness of the potential injuries and the likelihood of their occurrence, and that DSHS supervisors undertake a review of these citations to assure that they conform to HCFA guidelines.

The federal regulations specify that the resident environment in the nursing home must remain as free of accident hazards as possible. Physical features in the nursing facility environment that can endanger a resident's safety are accident hazards. A major issue with this regulation is the excessive interpretation that surveyors take with respect to what constitutes an accident hazard.

The HCFA guidelines for evaluation of hazardous conditions indicate that conditions cited should be serious enough in terms of the potential injuries and likely frequency to warrant citation. Hazardous conditions may be cited when the potential injury is very serious, even if the occurrence is relatively rare or unlikely; when the potential injury is less serious, citations should reflect a commensurately higher incidence or likelihood. Our review of a number of citations does suggest that, as might be expected, surveyors have tended to include conditions that offer possible danger without evaluating the likelihood of actual occurrence.

We do not recommend changes in the remaining nine regulations.

- 1) As providers recognize, the regulation concerning restraints does indeed impose substantial and burdensome barriers to the use of restraints, including documentation. However, these burdens appear to be intentional; the examples of excessive interpretation volunteered by providers appear, in fact, to conform to the HCFA guidelines. Further, the regulation appears to have been successful in substantially reducing the use of restraints.
- 2) The training requirements for nurse aides do not seem to be unreasonable or costly in and of themselves, nor did providers allege that the training was unnecessary. Rather, they seemed primarily concerned with the fact that they had to pay for the training of high turnover staff. The regulation seems irrelevant to this problem. Providers are free to hire only trained, experienced staff; that they chose not to reflects their difficulty in finding and keeping staff rather than the requirements of the regulation.

- 3) The issues with the regulation concerning specialized rehabilitation services seem rather to do with the reimbursement system than the regulatory requirement. We regarded these as outside our purview.⁶
- 4) We were unable to determine why the regulation concerning blood borne pathogens was so often regarded by providers as problematic and costly. We have suggested that DSHS review evidence on the incidence and prevalence of hepatitis and HIV infections in nursing homes to determine whether the regulations might be relaxed. We note, however, that relaxation of current requirements would require concurrence by OSHA.
- 5) Finally, the remaining regulations, dealing with sanitary kitchen facilities, infection control, maintenance of resident dignity, accommodation of need, and provision of a homelike environment, were selected based solely on their rates of deficiency citations and/or concerns with provider complaints of undue surveyor discretion in their interpretation. It appears that the deficiency citations for these regulations usually do not indicate a sustained and substantial failure to achieve their objectives, but rather indicate the need for steady monitoring to identify and correct often modest violations before they accumulate. Likewise, although issues of surveyor discretion and variation or inconsistency in interpretation are endemic, they are not, in these cases, associated with provider perceptions of excessive interpretation and do not seem to suggest a need for reforms in these regulations.

It is worth noting that all of the regulations for which we have recommended actions were selected based on the provider ratings in the LBC survey. This survey, or others like it, seem to us to provide a good vehicle for further efforts to identify useful reforms.

⁶ For further discussion about the Medicaid reimbursement system in Washington State, please refer to Nursing Home and Long Term Care- Part 1: Nursing Home Reimbursement, State of Washington, Legislative Budget Committee, Long Term Care- Part 1: Nursing Home Reimbursement Report 94-4; October 21, 1994.

Nursing Home Regulations in Washington State -- Addendum

Prepared by LBC Staff

USE OF PHYSICIAN/NURSE TREATMENT PROTOCOLS IN NURSING HOMES

Chapter One

The statute mandating this study directed that it specifically address:

“ . . . documentation or protocols that are redundant and efficiencies that could be realized through the development of standardized physicians’ protocols for repetitive but nonlife threatening conditions.”

To the extent that documentation requirements associated with the various regulatory areas addressed in the Nursing Home Regulation study are viewed as problematic, they are addressed in Chapter 3 of the consultant’s report. This chapter, therefore, is limited to the issue of standardized physicians’ protocols.

Definition and Purpose

As indicated above, the statutory directive was that this study examine the issue of “physicians’ protocols.” There is little agreement, however, as to what specifically is meant by this term, other than the fact that it does not accurately describe the issue that was intended to be discussed. Further, we were unable to identify any other widely accepted or recognized term that appeared to be appropriately descriptive and/or focused.

In general, protocols are a process standard that define the ongoing care and management of a broad problem or issue. Within the nursing home setting, some protocols may contain actions on the

What
protocols
are

part of a nurse which require direct physician involvement—including a physician's order—as well as some that do not. The primary focus of the issue being addressed here is on the latter; that is, nursing actions which do not require direct physician involvement.

As a matter of convenience, we have chosen to use the term "physician/nurse treatment protocol" (although it is not a term that is likely to be widely accepted or recognized). As used here, it refers to a protocol for patient care in a nursing home that is based upon a physician-directed process that allows a nurse the autonomy to make certain treatment decisions within a predetermined framework.

Intent is to eliminate unnecessary phone calls

For the purpose of this discussion, physician/nurse treatment protocols can be differentiated from other protocols in that their specific purpose is to allow a facility's nursing staff, within existing scope of practice parameters, to more fully utilize their professional skills, while lessening the need for direct, or immediate, physician involvement. Another, perhaps more direct explanation of their purpose is that they are specifically intended to eliminate the unnecessary phone calls that some nursing homes feel obligated to make to physician's offices.

Most of the individuals we consulted with indicated that to be effective, such protocols would need to be jointly developed by a facility's medical and nursing staff. Many felt that a key feature would be the inclusion of a "decision tree" which would serve, as part of the protocol's predetermined framework, to expand the range of activities a nurse was specifically directed to perform prior to contacting the physician. This is illustrated in the following example.

When encountering a particular condition covered by the protocol, it might indicate:

- If you observe A, do X. If you observe B, do Y. If you observe something other than A or B, call the doctor.

In the absence of such a protocol, the standard procedure might be as follows:

- If you observe A, do X. If you observe something other than A, call the doctor.

(Obviously the above is overly simplistic. It is intended only to help the reader obtain a better understanding of the general issue. "Real" protocols, with "real" decision trees would certainly be far more elaborate.)

An essential part of such a protocol is that in the event a treatment result, or the patient's condition, in any way falls outside the protocol's predetermined framework, the physician is notified and once again assumes immediate responsibility. Also, as indicated in the statute mandating this study, the expectation is that the use of such protocols in nursing homes would be limited to "repetitive but nonlife threatening" conditions. Examples include skin tears, Stage I and II decubiti (early-stage bed sores), and bowel and bladder care, including urinary tract infections.

Current Usage — Perceived Barriers

The type of physician/nurse treatment protocols described above are not in wide use in Washington's nursing homes. In a limited survey conducted by the Washington Health Care Association in the summer of 1994, less than ten percent of its member facilities reported having such protocols in place. In contrast, similar protocols have been reported to be generally in widespread use in both acute care hospitals and the home health industry.

According to nursing home industry representatives and others, some nursing homes have been reluctant to implement such protocols because they fear they will be cited by the state for inadequate patient care if they do; that is, they fear the state will automatically equate such protocols with inadequate care. Reportedly, this stems from a time more than ten years ago when the state, through the nursing home survey process, identified a number of problems associated with—and began to write numerous citations for—the widespread use of standing orders.

**Protocols not
currently in
widespread
use**

Staff from the Division of Nursing Home Services indicate the use of those orders was generally frowned upon because they did not provide for a plan of care that was sufficiently individualized. As envisioned here, physician/nurse treatment protocols would be much more comprehensive than standing orders.

According to management staff within the Department of Social and Health Services' Division of Nursing Home Services, there is nothing in state or federal nursing home regulations that prohibits the use of physician/nurse treatment protocols per se.

Efforts to Increase Usage

The Pierce County Medical Society Subcommittee on Aging, as part of a pilot project on skilled nursing facility care,¹ has been the primary source of efforts to develop and increase the use of these types of protocols in nursing homes. (This has been just one of the issues addressed through the pilot project—others are discussed below under Potential for Broader Application.)

The subcommittee—which has had participation from local nursing homes and hospitals, the nursing home associations and DSHS's Division of Nursing Home Services—has worked on developing drafts of various protocols. The chair of the subcommittee has indicated that he is particularly interested in developing a standardized format, or template, for protocols that can be used by other nursing homes. The intent, however, is that the specifics of each protocol would be developed individually by each facility's medical and nursing staff.

The issue appears to have broad support within the industry. In response to a question contained in the survey of nursing homes conducted by Abt Associates for the Nursing Home Regulation Study, 96 percent of respondents agreed that it would be appropriate to have a set of standardized protocols for repetitive but nonlife-threatening conditions that are common in a nursing home. When

Broad
support
within
industry for
having
standard-
ized
protocols

¹ Sponsored by the Washington State Medical Association.

asked whether standardized protocols would be appropriate for specific conditions:

- 94 percent said yes for skin tears;
- 85 percent said yes for stage I/II pressure sores;
- 92 percent said yes for bowel and bladder training;
- 58 percent said yes for urinary tract infections; and
- 42 percent said yes for "other."

Efficiencies That Could Be Realized Through Increased Use

The information below is based on internal office records developed by the chair of the subcommittee referenced above, who is a partner in a two-physician practice that specializes in geriatric medicine. While we have no reason to question its accuracy, it is important to note that we have not attempted to independently verify the data.

- During a one-month period in 1993, the practice logged a total of 1,272 phone calls from nursing homes regarding its 297 patients who were at that time nursing home residents. Of the total calls, 214 (16.8 percent) were identified as being for conditions that could be handled through the type of protocols discussed here.
- Through other observations, the practice has also determined that each phone call, on average, takes three minutes. Additionally, each phone call of the type noted above typically generates a form from the nursing home requesting the physician's signature to verify the telephone order. The practice estimates the average processing time for such a form to be one minute.

**Phone calls
could be
eliminated,
resulting in
time
savings**

Assuming the accuracy of the above information; the total time saved for this one practice would be 14.3 hours per month. This is based on 0.72 calls per patient per month avoided (214/297), and four minutes per call.

If the above figures were representative of geriatric physician practices in general, and could be applied to the entire statewide nursing home population of 28,000, the overall impact could be as follows:

- 20,160 calls avoided per month (241,920 per year), and
- 1,344 hours of time saved per month (16,128 per year)

The above represents potential "time-savings" that could accrue to physician offices. Presumably, an equal amount of time savings could also accrue to nursing homes (since they are the ones who initiate the phone calls).

Monetary savings also likely

Some amount of direct monetary savings could also be realized through eliminating the need to send forms through the mail (forms used to document the physician's order). For example, assuming a cost of \$.66 per form (\$.58 for two stamps, \$.04 for two envelopes and \$.04 for a "triplicate" form), total annual savings would be approximately \$160,000 based on the data above (that is, 241,920 forms avoided).

The executive director of the state's Nursing Care Quality Assurance Commission told us that the efficiencies offered by such protocols are not limited to time and cost savings. Specifically, it was noted that they can provide for more timely implementation of an appropriate treatment and diagnostic regimen, which can decrease the incidence of complications and reduce discomfort to a patient who would otherwise be "awaiting orders."

Potential for Broader Application

Protocols of the type discussed here are just one small part of a broader effort to streamline—and at the same time improve—patient care. This effort is being reviewed by a pilot project operated by the Pierce County Subcommittee on Aging. One area discussed by the group, for example, relates to the development of overall strategies for nursing home patient care, referred to as "clinical pathways," that are much more comprehensive in scope and application than the physician/nurse treatment protocols.

The subcommittee's chair told us that in addition to incorporating components related to direct patient care, such pathways might also include features such as: 1) a standardized process for transferring patient information between the hospital and the nursing home; 2) specific methods for patient charting that are intended to speed up and improve the process for assessing changes in a patient's condition, while also decreasing the amount of time devoted to this activity; and 3) the development of outcome measures and the incorporation of other features to permit objective assessment.

According to the subcommittee's chair, an impediment to the group's work has been the lack of standardized definitions for many of the terms that are integral to its discussion. The term "clinical pathway" is itself an example. Other examples include the terms: "critical paths," "clinical practice guidelines," and "protocols." The executive director of the Washington State Nursing Quality Assurance Commission also told us that there was often confusion over the meaning of different terms, and that people in the field may use certain terms but mean very different things by them.

DISCUSSION AND RECOMMENDATIONS

The development and implementation of physician/nurse treatment protocols, as described herein, would seem to offer efficiencies that could be realized both by the state's physicians who treat nursing home residents, and by the nursing homes themselves. A major obstacle to broader implementation appears to be the perception on the part of some nursing homes that state surveyors will automatically equate the use of such protocols with inadequate patient care, and the nursing home will be cited accordingly.

Management staff within the Division of Nursing Home Services acknowledge that there are no state or federal regulations that prohibit the use of such protocols per se, and that they are not viewed as being inextricably linked with inadequate patient care. They have not, however, gone "on record," or formally notified nursing homes of this fact; although they have indicated to us that this is something they could do. A spokesperson for one of the

Develop-
ment and
implemen-
tation could
result in
efficiencies

state's two nursing home associations told us that this simple act on the part of the Division would have a definite impact. We believe it is warranted.

In communicating this to the nursing homes, we believe it would be helpful and appropriate for the Division to put it in the context that:

- Maintaining the adequacy of patient care is paramount; and
- Using physician/nurse treatment protocols does not, in and of itself, conflict with adequate patient care. Rather, a major purpose of such protocols is to promote greater efficiency by reducing unnecessary communication, and to the extent they can do that without negatively impacting patient care, their use should be encouraged.

Recommendation 1

The Division of Nursing Home Services should formally notify the state's nursing homes that the use of physician/nurse treatment protocols, as described herein, is not prohibited by state or federal nursing home regulation.

[In its communication with the nursing homes, the Division should use whatever terminology, and include whatever caveats, it feels is appropriate (without circumventing the intent of the recommendation). It should also refer nursing homes to the Nursing Care Quality Assurance Commission if they have any questions as to whether specific actions within a protocol are within the scope of nursing practice.]

An assessment of "clinical pathways," as described above, is outside the scope of this review. At the same time, however, it is a concept which appears to offer at least the potential for improving patient care while achieving significant efficiencies. As such, we encourage the Pierce County Medical Society Subcommittee on Aging to continue its efforts in this area.

In addressing the issue of physician/nurse treatment protocols, we encountered substantial problems with definitions (to the point where we essentially had to develop our own term). As such, we recognize the difficulty associated with addressing a complicated issue when there is a lack of standardized definitions. Resolving this problem could facilitate efforts to achieve greater efficiencies in providing nursing home patient care.

Recommendation 2

The Division of Nursing Home Services, in consultation with the Nursing Quality Assurance Commission, should work with the Pierce County Medical Sub-Committee on Aging to develop formal—or at least mutually agreed upon—definitions for such terms as “clinical pathways,” “critical paths,” “clinical practice guidelines,” and “protocols.”

GOVERNMENTAL COSTS RELATED TO NURSING HOME REGULATION

Chapter Two

This chapter reports federal and state costs associated with the administration of health and safety regulations affecting nursing homes. Costs to local governments were not reviewed. Such costs would generally be limited to those associated with fire and life safety inspections. Our review was limited to identifying and reporting costs, rather than assessing the appropriateness of those costs.

Overview

Total Costs

As shown in Figure 1 on the following page, total state and federal costs in 1994 related to the administration and enforcement of health and safety regulations affecting nursing homes were estimated to be approximately \$8.2 million, or \$27,767 per licensed nursing home.

Most health and safety regulatory activities affecting nursing homes are centered within the Division of Nursing Homes Services, which is in the Department of Social and Health Services' Aging and Adult Services Administration. This division is responsible for developing and administering state nursing home regulations, as well as enforcing both state and federal regulations. (Specific activities of the division are detailed in Figure 2.) Given its broad

Figure 1

**Estimated State and Federal Costs Pertaining to the Administration
of Health and Safety Regulations Affecting Nursing Homes
1994**

Agency		Total Annual Costs	Description/Explanation
State	DSHS--Division of Nursing Home Services [1]	\$7,927,323	Estimated total costs to develop and administer state regulations, and enforce both state and federal regulations (see Figure 2 for listing of specific activities).
	Department of Health [2]	\$163,950	Estimated cost of conducting approximately 60 "construction reviews" per year, at an average cost of \$2732 per review.
	Department of Labor and Industries [3]	\$36,865	Estimated costs of conducting 12 health inspections, 20 safety inspections and 5 consultations per year (WISHA), at an average cost of \$1472, \$683, and \$1107 respectively.
Federal	Health Care Financing Administration [4]	\$63,162	Estimated cost for conducting approximately 15 federal "look-behind" surveys per year, at an average cost of \$4211 per survey.
TOTAL		\$8,191,300	Total costs per 295 licensed nursing homes equals \$27,767.

Notes: [1] Based on "HSQ8 Budget for Federal Fiscal Year 1994" (see footnote on preceding page). Includes approximately \$300,000 for sub-contracting with the State Fire Marshal's Office to conduct fire and life safety inspections. Approximately \$4.9 million (61.6 percent) is federal funds, while \$3.0 million (38.4 percent) is state funds.

[2] Based on information provided by DoH staff.

[3] Cost and inspection data provided by L&I staff.

[4] Cost and survey data provided by HCFA Region X staff. Survey data for October 1993 through mid-April 1994.

range of responsibilities, it is not surprising that over 96 percent of all governmental costs identified were attributable to this division.¹ Approximately 62 percent of the division's budget is derived from federal funds.

Other costs identified included those attributed to: 1) the state Department of Health for conducting building construction reviews; 2) the federal Health Care Financing Administration for conducting "look-behind" surveys, which are akin to an audit function, and 3) the state Department of Labor and Industries for conducting inspections and consultations in accordance with the Washington Industrial Safety and Health Act.

Division of Nursing Home Services Costs

Figure 2 provides a breakdown of the component parts of the Division of Nursing Home Services' [federal fiscal year] 1994 budget. As can be seen, the largest portion (86 percent) of the division's budget is attributed to the "survey section."

Approximately 98 employees are assigned to this section. This includes nine supervisory and nine clerical personnel, as well as 80 line-workers who have titles such as "Nurse Consultant Institutional," "Public Health Advisor," and "Quality Assurance Nurse."

These are the individuals who are primarily responsible for conducting the regulatory activities shown at the bottom of Figure 2. In brief, these activities are as follows:

¹ Budget figures for the Division of Nursing Home Services have been taken from the Washington State HSQB [Health Standards and Quality Bureau, Health Care Financing Administration] Budget For Federal Fiscal Year 1994. This document, which is required as a condition of federal Medicare/Medicaid funding, provides much greater detail on the component parts of the division's budget than is available through state budget documents. Due to differences in state and federal reporting requirements, the budget figures cited are *very slightly less* (approximately two percent) than the division's actual budget. Budget figures have been adjusted to exclude costs attributable to "ICF/MRs" [intermediate care facilities for the mentally retarded].

Most costs
attributed to
"survey section"

What is included among the Division's regulatory activities

- ☐ Annual Recertification Surveys: Inspections conducted at least annually as required by state and federal law to ensure compliance with applicable rules and regulations;
- ☐ Post Surveys and Credible Allegations: Follow-up visits conducted to ensure that problems identified through the regular survey process have been or are being addressed;
- ☐ Complaint Investigations: Investigations of complaints which may come from such sources as nursing home residents themselves, family members, employees, and the nursing home ombudsman office;
- ☐ Monitoring Visits: Follow-up visits conducted after a particularly serious problem has been identified, either through a regular survey or a complaint investigation (the severity of the problem being monitored is the distinguishing feature between these visits and those noted under "post surveys and credible allegations" above), and
- ☐ Hearings: Hearings are held if a facility formally challenges a citation issued during the survey process or as a result of a complaint investigation.

Figure 2

Components of DSHS Division of Nursing Home Services Budget* and Costs Attributed to Individual Survey Section Activities (Federal Fiscal Year 1994)			
Components of Division of Nursing Home Services Budget			
Component	Cost	% of Total	
Nursing Home Services Director's Section	\$142,828	1.8%	
Nursing Home Services Policy Section	\$146,801	1.9%	
Consumer Affairs/Nurse's Aide Registry	\$517,672	6.5%	
Fire Marshal (Sub-Contracting Costs)	\$297,943	3.8%	
Survey Section	\$6,822,079	86.1%	
Total	\$7,927,323	100.0%	
Costs Attributed to Individual Survey Section Activities			
Note: Based on number of staff years listed as having been devoted to each activity.			
Activity	Total Activity Cost	Average Cost	Activity Cost As a % of Total Cost
Annual Recertification Surveys (316)	\$2,634,945	\$8,338	38.6%
Post Surveys and Credible Allegations (295)	\$286,996	\$973	4.2%
Complaint Investigations (4,250)	\$1,809,831	\$426	26.5%
Monitoring Visits (107)	\$34,410	\$322	0.5%
Hearings (26)	\$210,416	\$8,093	3.1%
Staff Meetings, Training and Education	\$1,845,480	N/A	27.1%
Total	\$6,822,078		100.0%

* Source: Washington State HSQB Budget for Federal Fiscal Year 1994. Of the total, approximately \$4.9 million (61.6 percent) is federal funds, and \$3.0 million (38.4 percent) is state funds.

SUMMARY OF RECOMMENDATIONS

Appendix 1

Recommendations by Abt Associates

Recommendation 1

The LBC and DSHS should petition HCFA to eliminate the regulation governing residents' right to refuse certain transfers, that is, transfers to and from a distinct-part Medicate unit.

Legislation Required:	No
Fiscal Impact:	Indeterminate
Implementation	July 1995

Recommendation 2

DSHS should clarify the situations in which providers should undertake investigations of possible patient abuse.

Legislation Required:	No
Fiscal Impact:	Indeterminate
Implementation	July 1995

Recommendation 3

DSHS should pursue efforts to identify a subset of sections and/or items on the uniform comprehensive needs assessment protocol that are not relevant for short-stay rehabilitative residents. If this effort is successful, DSHS will need to apply to HCFA for a waiver of the MDS requirements for such residents.

Legislation Required:	No
Fiscal Impact:	Indeterminate
Implementation	January 1996

Recommendation 4

DSHS and provider organizations should work together to develop and communicate prototype systems to incorporate the Minimum Data Set (MDS) needs assessment and Resident Assessment Protocols (RAPS) into provider operating systems so that providers can then develop effective resident care plans.

Legislation Required:	No
Fiscal Impact:	None
Implementation:	January 1996

Recommendation 5

DSHS should revise its procedures to explicitly require that surveyors support citations of nursing homes for hazardous situations with both an assessment of the seriousness of the potential injuries and the likelihood of their occurrence, and that DSHS supervisors undertake a review of these citations to assure that they conform to HCFA guidelines.

Legislation Required:	No
Fiscal Impact:	None
Implementation:	July 1995

Recommendations by LBC Staff***Recommendation 6***

The Division of Nursing Home Services should formally notify the state's nursing homes that the use of physician/nurse treatment protocols, as described herein, is not prohibited by state or federal nursing home regulations.

Legislation Required:	No
Fiscal Impact:	Minor cost savings possible
Implementation:	July 1995

Recommendation 7

The Division of Nursing Home Services, in consultation with the Nursing Quality Assurance Commission, should work with the Pierce County Medical Sub-Committee on Aging to develop formal—or at least mutually agreed upon—definitions for such terms as “clinical pathways,” “critical paths,” “clinical practice guidelines,” and “protocols.”

Legislation Required:	No
Fiscal Impact:	None
Implementation:	January 1996

AGENCY RESPONSES TO NURSING HOME REGULATIONS STUDY AND ADDENDUM

Appendix 2

- **Department of Social and Health Services
Aging and Adult Services Administration**
- **Washington State Nursing Care Quality
Assurance Commission**



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia, Washington 98504-0095

RECEIVED

JAN 27 1995

LEGISLATIVE
BUDGET COMM

January 25, 1995

Cheryle Broom, Legislative Auditor
State of Washington
Legislative Budget Committee
Post Office Box 40910
506 16th Avenue Southeast
Olympia, Washington 98504-0910

Dear Ms. Broom:

Attached is the Department of Social and Health Service's response to the Nursing Home Regulation study preliminary report. I appreciate the opportunity to make these comments.

I want to commend the Legislative Budget Committee staff for this report. The issues involved with this study are very complex. Nursing home regulations must strike a balance between common sense and the protection of nursing home residents.

The recommendations contained in the report suggest several areas where regulations can be improved to reduce the paperwork without negatively impacting quality of care provided to nursing home residents. The department has already begun to develop a work plan in conjunction with the nursing home industry and consumer groups for the implementation of these recommendations.

If you need more detailed information, please contact Cathy Wiggins, Director, Division of Residential Care Services at 493-2560.

Sincerely,

A handwritten signature in dark ink, appearing to read "Charles E. Reed".

Charles E. Reed, Assistant Secretary
Aging and Adult Services Administration

cc: Jean Soliz
Cathy Wiggins

Response to LBC Recommendations

Recommendation	Agency Position	Comments
1) The LBC and DSHS should petition HCFA to eliminate the regulation governing resident's rights to refuse certain transfers, that is, transfers to and from a distinct-part Medicare unit.	Concur	DSHS will forward this request to HCFA by June 1, 1995.
2) DSHS should clarify the situations in which providers should undertake investigations of possible patient abuse.	Concur	<p>The department has worked diligently with providers since early 1993 to reduce the volume of complaint reports and clarify expectations regarding investigation. (See attached chart.) These efforts have produced a tremendous reduction in reporting and improved investigations. The department is interested in continuing to improve the system and will gladly seek any clarification that can be provided by HCFA. However it needs to be noted that such clarification was not made in the recently adopted federal regulations that go into effect in July 1995.</p> <p>In addition whether or not federal clarification can reduce provider responsibility for investigations is unclear because part of the standard of nursing practice in this state requires nurse assessment of injuries of their patients, documentation of actions, creation of a care plan and development of appropriate interventions related to elimination of further harm. It is not clear that current abuse and neglect investigation and reporting requirements exceed those standard nursing practices. It is, therefore, not clear that any change in abuse and neglect requirements will result in a real reduction in provider efforts.</p>
3) DSHS should pursue efforts to identify a subset of sections and/or items on the uniform comprehensive needs assessment protocol that are not relevant for short-stay rehabilitative residents. If this effort is successful, DSHS will need to apply to HCFA for a waiver of the MDS requirements for such residents.	Concur	The Department has already begun to work on recommendations 3 and 4. A work group composed of representatives from the nursing home industry, other health care providers, consumer groups and departmental staff has been formed. The first meeting is scheduled for early February. A report from this group is anticipated by early summer. A sample letter to the workgroup and a list of invitees are attached.
4) DSHS and provider organization should work together to develop and communicate prototype systems to incorporate the Minimum Data Set (MDS) needs assessment and Resident Assessment Protocols (RAPs) into provider operating systems so that providers can then develop effective resident care plans.	Concur	See above comment.

Response to LBC Recommendations

Recommendation	Agency Position	Comments
<p>5) DSHS should revise its procedures to explicitly require that surveyors support citations of nursing homes for hazardous situations with both an assessment of the seriousness of the potential injuries and the likelihood of their occurrence, and that DSHS supervisors undertake a review of these citations to assure that they conform to HCFA guidelines.</p>	<p>Concur</p>	<p>Surveyors and managers will receive training on how to assess and document hazardous situations to determine both the seriousness of any potential injury and the likelihood of occurrence. District Managers will be responsible for monitoring. This activity will be completed by June 1, 1995.</p>
<p>The Division of Nursing Home Services should formally notify the state's nursing homes that the use of physician/nurse treatment protocols, as described herein, is not prohibited by state or federal nursing home regulation.</p>	<p>Concur</p>	<p>No comment</p>
<p>The Division of Nursing Home Services, in consultation with the Nursing Home Quality Assurance Commission, should work with the Pierce County Medical Sub-Committee on Aging to develop formal—or at least mutually agreed upon—definitions for such terms as "clinical pathways," "critical paths," "clinical practice guidelines," and "protocols."</p>	<p>Partially concur</p>	<p>We concur with the report's conclusion that lack of standardized definitions of terms such as "protocols" and "clinical pathways" causes confusion among practitioners. We do not believe, however, that DSHS should take a lead role in the development of standardized definitions. This responsibility rests with the Nursing Care Quality Assurance Commission because the standardized definitions involve standard of practice.</p> <p>Coordinating efforts among the Pierce County Medical Society Sub-committee on Aging (and other interested physician groups), the DSHS and the Nursing Care Quality Assurance Commission may be a helpful approach as long as the Nursing Care Quality Assurance Commission is recognized as the only appropriate body to produce and publish standardized nursing practice definitions. In this effort, DSHS could play an important role in ensuring that the definitions comply with nursing home regulations.</p>



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
WASHINGTON STATE NURSING CARE QUALITY ASSURANCE COMMISSION
P.O. Box 47864 • Olympia, Washington 98504-7864

January 25, 1995

TO: Rob Krell
Legislative Budget Committee

FROM: Pat Brown, Executive Director
Nursing Commission

RE: Response to Recommendation 7, Nursing Home Regulations

As Executive Director to the Nursing Care Quality Assurance Commission, I would respond on their behalf that definitions regulating nursing practice are more appropriately placed in WAC's promulgated by the Commission.

A definition in Nursing Home regulations for protocols, for example, may not be parallel to acute care setting protocols and can create confusion among practitioners.

LBC Staff Auditors' Note:

In its response, the Division of Nursing Home Services also indicated the belief that the Nursing Care Quality Assurance Commission was the most appropriate Body to Implement Recommendation 7. Although having the Nursing Commission establish formal definitions in rule would be a more formal and far-reaching solution than we had envisioned, we would have no objection since it would still result in the intent of the recommendation being achieved.